JUNE 2008 | VOLUME 1 | Quarterly Publication

➤ ***Research & Development***
BV or not BV? Recent Advances in Bacterial Vaginosis (BV) *.....pg 2*

➤ ***Legal Corner***
The latest on competitive bidding *.pg 3*

➤ ***New Test Announcements***
New tests now available at MDL *..pg 4*

The Laboratorian SM

WHAT'S INSIDE ➤➤

UPCOMING EVENTS ➤➤

06/10	**UPIDHM:** University of Pennsylvania Infectious Disease Herpes Meeting **Philadelphia, PA**
06/25-27	**MDFP:** Maryland Academy of Family Physicians **Cumberland, MD**
07/24-27	**PHM:** Pediatric Hospital Medicine 2008 Annual Conference **Denver, CO**
09/10-13	**UMDNJ:** University of Medicine & Dentistry of NJ School of Osteopathic Medicine 12th Annual Board Review **Mt Laurel, NJ**
09/12-13	**WHCF:** Women's Healthcare Forum: Chicago Meeting **Rosemont, IL (Chicago)**
09/19-21	**WHCF:** Women's Healthcare Forum: Philly Meeting **Philadelphia, PA**

PREMATURE RUPTURE OF MEMBRANES (PROM)

Author: Dr. Shlomo Stemmer

Premature rupture of membranes (PROM) is defined as spontaneous rupture of the chorioamniotic membranes prior to the onset of labor. PROM occurs in about 10% to 15% of all pregnancies and is usually followed by the onset of labor. Preterm premature rupture of membranes (PPROM) is the spontaneous rupture of membranes before 37 weeks gestation. PPROM occurs in 3% of all pregnancies and is associated with significant perinatal morbidity and mortality. PPROM is responsible for about one-third of preterm deliveries and in about 75% of the cases, delivery occurs within one week of membrane rupture.

The cause of PROM is usually multifactorial and often unknown. At term, weakening of the fetal membranes may result from contractions. Intrauterine infection or inflammation is more commonly the cause of PPROM. Sexually transmitted diseases and bacterial vaginosis (BV) are more frequently found in women with PROM. Other factors associated with PROM are cigarette smoking during the current pregnancy, low socioeconomic conditions, previous preterm birth, prior cervical conization, cervical cerclage, amniocentesis, vaginal bleeding, multifetal pregnancy and polyhydramnios or too much amniotic fluid in the amniotic sac.

Diagnosis of PROM is most commonly made by the patient's medical history and an observation of fluid passing or pooling in the vagina. A positive nitrazine test and/or ferning of the fluid almost always confirms the diagnosis. Differential diagnosis includes urinary incontinence, cervicitis, vaginitis, passing of the mucous "plug" and the presence of semen or douche. If the diagnosis is uncertain, ultrasound evaluation of the level of amniotic fluid may be helpful. However, ultrasound alone cannot confirm the diagnosis since olighydramnios (low levels of amniotic fluid) is possible. Amnioinfusion of indigo-carmine dye and observation of the presence of this dye in the vagina confirms the diagnosis. If PROM is suspected, a sterile speculum examination to assess cervical dilation, obtain cultures and evaluate the vaginal fluid is performed. Digital vaginal examination should be avoided to decrease the risk of infection.

PROM complicates 10% to 15% of all pregnancies.

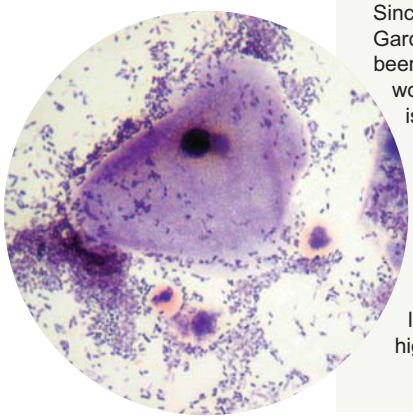
Management of term PROM can be expectant, by waiting up to 12 to 24 hours for labor to start, or active by inducing labor using oxytocin. Prior to induction of labor, gestational age, fetal presentation and Group B Streptococcal (GBS) status should be determined. Immediate induction of labor is advised if risk factors exist such as multiple digital examinations or signs and symptoms of chorioamnionitis are present.

Management of PPROM is controversial and varies among centers. Patients managed conservatively have a 75%

Continued ..... pg 2

BV OR NOT BV?

Author: Dr. Spencer Hedges



RECENT ADVANCES IN BACTERIAL VAGINOSIS (BV)

Since the ground-breaking research by Gardner and Dukes in the 1950's, it has been understood that the vaginal flora of women without bacterial vaginosis (BV) is different from that of women with BV. In women without BV, Lactobacillus species are predominant. Despite the presence of many other bacterial species in the vagina, including in many cases the same bacteria that are associated with or are possibly the etiological agents of BV, the levels of Lactobacillus are logs-fold higher than other competing bacteria. In contrast, women with BV have numbers of Lactobacillus which are much reduced or virtually absent, and the vaginal flora is dominated by anaerobic Gram-positive and Gram-variable bacteria. The mechanism of how the vaginal flora can change so distinctly is unknown. It is clear from epidemiological research, however, that human behaviors including sexual activity and douching, among others, are risk factors for BV.

BV is diagnosed in two ways. The most common guideline for BV diagnosis, used

Continued ..... pg 2

Message From the CEO

Medical Diagnostic Laboratories, L.L.C.
CEO: Eli Mordechai, Ph.D.

We are delighted to launch our first quarterly journal, ***The Laboratorian***[SM]***.*** The mission of the *The Laboratorian*[SM] is to serve mainly as a communication bridge between the clinical laboratory and its clients. Such a bridge will continually foster educational programs, quarterly laboratory updates on new clinical diagnostic tests, breakthrough in clinical research, and much more. The journal is authored and reviewed by experienced world-renowned physician writers and editors and will provide current clinical review. In addition, *The Laboratorian*[SM] has a "journal watch corner" that summarizes recent articles from over fifty journals in the fields of Infectious diseases, cancer, and immune-based diseases. Published four times yearly, *The Laboratorian*[SM] serves as the only platform for presenting clinical laboratory oriented discussions and policies to our clients. Your continual review, criticism and input is essential to the success of *The Laboratorian*[SM].

BV OR NOT BV? RECENT ADVANCES IN BACTERIAL VAGINOSIS (BV)

Continued from pg 1

in a clinical setting, is known as the Amsel criteria. This relies on the clinical observation of signs and symptoms of BV including discharge, odor, lowered pH, and the presence of clue cells (epithelial cells surrounded by a biofilm "beard" of anaerobic bacteria). The second method for BV diagnosis, usually used in a laboratory setting, is known as the Nugent criteria. This is a semi-quantitative evaluation of vaginal Gram-positive and Gram-variable bacterial morphotypes that accounts for the numbers of Lactobacillus, *Gardnerella vaginalis*/ Prevotella, and Mobiluncus species. However, both methods of diagnosis lack sensitivity.

The current (2006) Centers for Disease Control and Prevention (CDC) guidelines for treatment of BV include: oral Metronidazole (500 mg) twice a day for 7 days; intravaginal Metronidazole gel 0.75% (5 g), once a day for 5 days; intravaginal clindamycin cream 2% (5 g) for 7 days. Single dose oral Metronidazole (2 g) is no longer a recommended therapy due to its poor efficacy. Longer treatment regimens may be useful for recurrent or chronic disease. A recent observational study performed in collaboration with Medical Diagnostic Laboratories, L.L.C. (MDL) Research & Development Department suggested that 5 weeks of treatment with intravaginal Clindesse® (clindamycin sulfate vaginal cream 2%) significantly reduced patient symptoms and the presence of BV-associated bacterial species.

Research in the BV arena has recently been energized in two ways. Firstly, by indications of novel vaginal bacteria shown to be more prevalent in women with BV compared to women without BV using molecular techniques. The first of these bacteria to be identified as such was *Atopobium vaginae*. Subsequent studies have identified other organisms including Megasphaera and Eggerthella species as well as three as of yet unclassified microorganisms that were more prevalent in women with BV. The second area of recent diagnostic interest, which has taken advantage of the identification of the new BV-associated bacteria, is data from a prospective study performed by MDL suggesting differences in the bacteria associated with BV comparing African-Americans and Caucasians. Similarly, another recent study has indicated differences in the carriage of those organisms prior to illness. The results of these studies may indicate that BV may constitute different disease entities in different populations.

The need for STD screening-

Adapted from: Selected STD's and complications Initial visits to physicians' offices, National Disease and Therapeutic Index: United States.

	2005	2006
Genital Herpes	266,000	371,000
Genital Warts	357,000	422,000
Vaginal Trichomoniasis*	165,000	200,000
Other Vaginitis*	4,071,000	3,891,000
Pelvic Inflammatory Disease †	176,000	106,000

**Women only*
† Women 15 - 44 only

http://www.cdc.gov/std/stats/tables/table42.htmw.cdc.gov
Accessed May 1, 2008.

PREMATURE RUPTURE OF THE MEMBRANE (PROM)

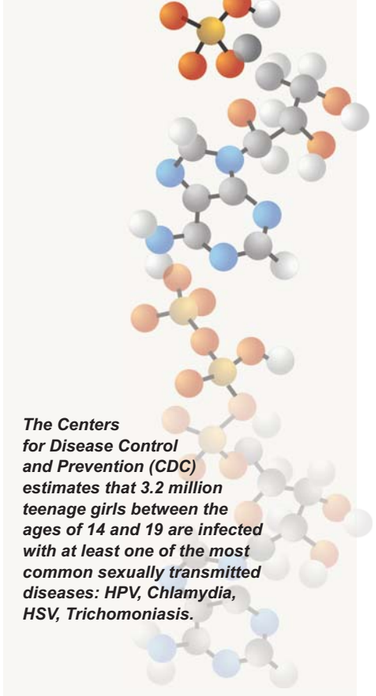
Continued from ..... pg 1

likelihood of delivering within one week. Delivery near term, after 32 to 36 weeks, involves low fetal morbidity once lung maturation has occurred. Fluid from the vaginal pool should be collected, if possible, and tested for a lecithin/sphingomyelin (L/S) ratio to measure maturity of the fetal lungs. If the vaginal pool fluid is not sufficient for analysis, amniocentesis may be considered. Once the presence of pulmonary lung maturity has been determined, delivery should be considered, as expectant management may increase the risk of amnionitis.

PPROM remote from term, occurring 23 to 31 weeks gestation, is associated with significant fetal morbidity and mortality upon delivery. Conservative management with the aim to allow the fetus to mature *in utero* as long as possible should be attempted. The risk of conservative management includes amnionitis, placenta abruption, cord compression and fetal distress. Maternal rest and increased hydration may lead to amniotic fluid re-accumulation and membranes resealing. Daily assessment for fever, uterine tenderness and monitoring for fetal distress should be performed as well as periodic white blood cell count and fetal ultra-sound evaluation. A single dose of corticosteroids, to enhance fetal lung maturity, should be administered and antibiotics should be given to prolong the time from PROM to delivery and prevent an ascending infection. There are no studies available which demonstrate that the use of tocolytics improves neonatal outcome, however, it is reasonable to utilize tocolytics in patients with PPROM to allow the administration of corticosteroids and antibiotics.

Previable preterm PROM refers to PROM prior to 23 weeks gestation. In addition to the risks of prematurity and perinatal infection, the very premature fetus is at risk of pulmonary hypoplasia. Up to 80% of infants may survive, however, serious complications such as developmental delays, delayed motor development, cerebral palsy, mental retardation, hydrocephalus and lung disease are common. Women presenting with PROM, before fetal viability, should be advised about the potential risks and benefits of expectant management compared to immediate delivery. Realistic expectations about the outcome of the pregnancy, the availability of fetal monitoring and neonatal intensive care should be discussed.

In conclusion, PROM complicates 10% to 15% of all pregnancies. In the United States, PROM affects 120,000 pregnancies annually. Management of PROM varies with gestational age and the benefits of immediate delivery versus expectant management should be evaluated continuously until delivery. More attention and research should be given to prevention of PROM as it is associated with significant maternal and fetal morbidity and mortality.



The Centers for Disease Control and Prevention (CDC) estimates that 3.2 million teenage girls between the ages of 14 and 19 are infected with at least one of the most common sexually transmitted diseases: HPV, Chlamydia, HSV, Trichomoniasis.

LEGAL CORNER

Author: Mark A. Lieberman, Esq. General Counsel

For this inaugural issue of "*The Laboratorian*™" we discuss a milestone decision involving efforts by the Centers for Medicare and Medicaid Services (CMS) to implement competitive bidding to select only a few clinical laboratories to provide testing that is reimbursed by Medicare.

When Congress passed the Medicare reform law in 2003, they included a requirement for CMS to conduct a Demonstration Project on laboratory services reimbursable under the Medicare Part B clinical laboratory fee schedule. However, from the onset of CMS's efforts, laboratories and others in the healthcare community have lobbied Congress, claiming that competitive bidding focuses only on the costs of laboratory testing and that if implemented, competitive bidding will artificially reduce the number of clinical lab choices available to patients as smaller, specialized labs that are leaders in advanced genetic testing and other cutting edge diagnostics are driven out of business.

While several bills have been introduced to block the Demonstration, Congress has not acted. At the same time, CMS moved ahead selecting the San Diego area as the first of two locations for a competitive bidding demonstration.

Shortly after the demonstration site was announced, a lawsuit was filed by three San Diego laboratories, Sharp Healthcare, Internist Laboratory and Scripps Health seeking to enjoin the Demonstration Program. On April 8, 2008, a US District Court Judge granted a preliminary injunction temporarily stopping CMS.

The Judge ruled that CMS did not follow notice and comment requirements required by law as it developed the Demonstration Project. This decision by no means ends the court action, nor does it end the push for competitive bidding. However, it is a significant set back for CMS which is now barred from:

- Announcing the winners of the Competitive Bidding Demonstration in the San Diego area
- Implementing or carrying out any aspects of the Demonstration
- Disclosing any of the information included in the bid application

We will continue to monitor and report on material developments.

~ ~ JOURNAL WATCH ~ ~

Evaluation of mixed infection cases with both herpes simplex virus types 1 and 2.
Kaneko H, et al.

J Med Virol; 80(5):883-7, May 2008

Herpes simplex virus type 1 (HSV-1) is isolated principally from the upper half of the body innervated by the trigeminal ganglia whereas herpes simplex virus type 2 (HSV-2) is generally isolated from the lower half of the body innervated by the sacral ganglia. However, recent reports suggest that HSV-1 and HSV-2 can each infect both the upper and lower half of the body causing a variety of symptoms and there is a possibility that HSV-1 and HSV-2 infections can occur simultaneously with both causing symptoms. HSV type in clinical isolates from 87 patients with genital herpes and 57 with ocular herpes was determined by the polymerase chain reaction (PCR), and six cases of mixed infection with both HSV-1 and HSV-2 were identified. Of the six cases, three were patients with genital herpes and three were ocular herpes patients. There was no obvious difference between the clinical course of mixed infection and those of single HSV-1 or HSV-2 infections. This study indicated that the frequency of mixed infection with both HSV-1 and HSV-2 is comparatively higher than those of previous reports.

An Analysis of High-Risk Human Papillomavirus DNA-Negative Cervical Precancers in the ASCUS-LSIL Triage Study.
Castle, Phillip, Ph.D., MPH 1, et al.

Obstetrics & Gynecology, Vol. 111(4), 847-856, April 2008

A study was recently conducted on women diagnosed with cervical intraepithelial neoplasia-grade 3 (CIN-3) diagnosed over a 2-year duration of the atypical squamous cells of undetermined significance (ASCUS) and low-grade squamous intraepithelial lesion (LSIL) Triage Study (ALTS) that tested negative for high—risk Human papillomavirus (HPV) at enrollment. Pathologists evaluated any CIN-3 diagnosis on biopsy or loop electrosurgical excision procedure (n=621). HPV (high-risk) and two HPV assays were performed on enrollment cervical specimens. It is less common for High-risk HPV-negative CIN-3 cases to have a second, confirming diagnosis of CIN-3. In this study, evidence demonstrated that is was due to incident new cases (n=12, 19%), non-high risk HPV (n=5, 0.8%), misclassified histology (n=8, 1.3%), and false-negative high-risk HPV (n=8, 1.3%). It was concluded that, anywhere, there will be a few cases of cervical pre-cancer that will test high-risk for a variety of reasons amongst women that have cytologic abnormalities.

Intraptum Group B Streptoccocci Prophylaxis in Patients Reporting a Penicillin Allergy
Matteson, Kristen A. MD, et al.

Obstetrics & Gynecology. Vol. 111 (2, Part 1), 356-364, February 2008

A retrospective cohort study of GBS positive penicillin-allergic obstetric patients was conducted by analyzing the type of delivery, gestational age at delivery, antimicrobial sensitivity testing, and antibiotics administered. Overall, 95% (95% confidence interval [CI] 91-97%) of GBS-Positive, penicillin-allergic women received antibiotic prophylaxis and only 16% (95% CI 11-21%) of patients received an appropriate antibiotic. The majority of women who were given antibiotics received clindamycin (83%, 95% CI 77-87%); however, antimicrobial sensitivity testing was performed in only 11% (95% CI 9-17%) of patients. Adherence to the 2002 CDC guidelines for GBS prophylaxis in penicillin-allergic women is far from optimal. Improvements are necessary in obtaining antimicrobial sensitivity testing and choosing an appropriate antibiotic for GBS-positive women with a reported penicillin allergy.

Prevalence of Urinary Tracy Infection in Childhood A Meta-Analysis
Nader Shaikhj, MDL, MPH, et al.

Pediatric Infect Dis. J;27:302-308, February 2008

A recent meta-analysis study examined collective occurrence of urinary tract infection (UTI) in children by age, gender, race, and circumcision status. 7% of infants who presented a fever were diagnosed with an UTI. On average, 5.7% of females under the age of 12 months presented symptoms of UTI. 2.4% of febrile male infants less than 3 months and 20.1% of uncircumcised males had and a UTI. Additional studies were conducted based on race, Caucasian infants were compared to African American infants. It was found that 8.0% Caucasian infants were infected with a UTI compared to 4.7% of African American infants. Furthermore, the prevalence amongst older children under the age of 19 showed 7.8% were experiencing UTI symptoms. In conclusion, prevalence rates of UTI varied by age, gender, race and circumcision status. Based on the study, male infants under 3 months and female infants under 12 months were more susceptible to UTIs.

Type-Specific Duration of Human Papillomavirus Infection: Implications for Human Papillomavirus Screening and Vaccination.
Trottier H, et al.,

J Infect Dis. Vol. 197 (10). 1436-1447, May 2008

The duration of human papillomavirus (HPV) infection as a function of age, number of sexual partners, and coinfection with multiple HPV types was examined by PCR on 2,462 women who enrolled in the Ludwig-McGill cohort study. At enrollment, the prevalence of infection with high-risk HPV types was 10.6%, and the prevalence of infection with low-risk HPV types was 6.1%; incidence rates were 6.1 and 5.0 infections per 1000 women-months, respectively. Prevalent infections took longer to clear than incident infections (mean time to clearance, 18.6 months vs. 13.5 months). The mean duration of incident infection with high- and low-risk HPV varied according to the analytic approach used to measure this variable and showed considerable variation by HPV type (range, 5.1-15.4 months). Age and number of partners did not influence infection duration, whereas coinfection was associated with increased infection duration. The mean duration of HPV-16 monoinfection was 11.0 months, and the mean duration of HPV-16 coinfection was 15.4 months.

Recent Publications

MEDICAL DIAGNOSTIC LABORATORIES, L.L.C.

Abstracts

Vermitsky, J.P., Self, M.J., Katiyar, S., Mordechai, E., Adelson, M.E., Edlind, T.D., and Gygax, S.E. The cAMP Protein Kinase A signal transduction pathway negatively regulates Pdr1, the master regulator of azole resistance in *Candida glabrata*. March 24-28, 2008. 9th ASM Conference on Candida and Candidiasis, Jersey City, NJ.

Katiyar, S., Vermitsky, J.P., Gygax, S.E., and Edlind, T.D. Anatomy of *Candida glabrata* PdR1, master regulator of azole resistance: evidence for activation by MAP kinase Slt2. March 24-28, 2008. 9th ASM Conference on Candida and Candidiasis, Jersey City, NJ.

Edlind, T.D., Vermitsky, J.P., Pfaller, M., Gygax, S.E., and Katiyar, S. Molecular mechanisms behind fluytosine resistance and azole-fluctysine antagonism in *Candida glabrata*. March 24-28, 2008. 9th ASM Conference on Candida and Candidiasis, Jersey City, NJ.

Biggs, C., Overmyer, C., DeSalvia, L., Gonzalez, D., Gofman, L., Feola, M., Iacono, K., Mordechai, E., Adelson, M.E. Geographic Distribution of Pediatric Respiratory Infections: A Bi-Coastal Analysis. March 27-30, 2008. Molecular Medicine, Lake Buena Vista, FL.

Trama, J.P., Hilbert, D.W., Pascal, K.E., Libby, E.K., Mordechai, E., Adelson, M.E. Uropathogenic *E. coli* subverts innate immune function of bladder epithelial cells. April 5-9, 2008. Experimental Biology 2008, San Diego, CA.

Biggs, C., Overmyer, C.L., DeSalvia, L., Gonzalez, D., Gofman, L., Feola, M., Iacono, K.T., Mordechai, E., Adelson, M.E. A comparison of Nasopharyngeal and midturbinate region sampling for the detection of respiratory infections. April 27-30, 2008. 24th Clinical Virology Symposium, Daytona Beach, FL.

Stemmer, S., Adelson, M.E., Mordechai, E., Trama, J. Detection Rates of *Trichomonas vaginalis*, in Different Age Groups, using Real-Time PCR. May 3-7, 2008, American College of Obstetricians and Gynecologists, New Orleans, LA.

Stemmer, S., Adelson, M.E., Mordechai, E., Trama, J. Detection of Human Papillomavirus in U. S. Women Using Real-Time PCR: Prevalence and Genotypes Distribution. May 3-7, 2008, American College of Obstetricians and Gynecologists, New Orleans, LA.

Hilbert, D.W., Paulish, T.E., Libby, E.K., Pascal, K.E., Mordechai, E., Adelson, M.E., Gygax, S.E., Trama, J.P. O Serotypes, Virulence Factors, Plasmid Replicons and Antibiotic Resistance of Rectal and Cervico-vaginal *Escherichia coli* Isolates. June 1-5, 2008, 108th ASM General Meeting, Boston, MA.

Villasmil, M., Brower, M., Ansbach, A., Nickels, J.T. The putative lipid transporter, Arv1, is required for mating in *Saccharomyces cerevisiae*. July 22-27, 2008, Yeast Genetics and Molecular Biology Meeting, Toronto, Canada.

Gallo, C., Brower, M., Shirzadi, R., Nickels, J.T. The SRE-dependent and –independent transcriptional regulation of sterol gene expression in *Saccharomyces cerevisiae*. July 22-27, 2008, Yeast Genetics and Molecular Biology Meeting, Toronto, Canada.

Nguyen, M.L., Aubert, M., DiMiao, D., Blaho, J.A. p53 and hTERT Determine Sensitivity to Herpes Simplex Virus Dependent Apoptosis. July 27-August 1, 2008, 33rd Annual International Herpesvirus Workshop, Estoril, Portugal.

Peer-Reviewed Papers

Vermitsky JP, Self MJ, Chadwick SG, Trama JP, Adelson ME, Mordechai E, Gygax SE. (2008) A Survey of Vaginal-flora *Candida* species of Different Age Groups Using species-specific PCR Detection. *Journal of Clinical Microbiology,* **46(4):**1501-3.

Trama J.P., Pascal K.E., Zimmerman J., Self M.J., Mordechai E., Adelson M.E. Rapid detection of *Atopobium vaginae* and association with organisms implicated in bacterial vaginosis. *Mol Cell Probes*, **22(2)**:96-102.

Hilbert, D.W., Pascal, K.E., Mordechai, E., Adelson, M.E., Trama, J.P. (2008) Uropathogenic *Escherichia coli* suppress innate immune response of bladder epithelial cells. *Microbes and Infection,* **10(2)**: 114-21.

Libby, E.K., Pascal, K.E., Mordechai, E., Adelson, M.E., Trama, J.P. (2008) *Atopobium vaginae* triggers an innate immune response in an *in vitro* model of bacterial vaginosis. *Microbes and Infection*, In press.

Cotter, C.R., Blaho, J.A. (2008) Detection of Herpes Simplex Virus Dependent Apoptosis. *Methods in Molecular Biology,* In press.

HUMIGEN

Peer-Reviewed Papers

DM. Laube, A.Donagari-Bagtzoglou, H. Kashleva, J. Eskdale, G. Gallagher, G. Diamond. "Differential regulation of innate immune response genes in gingival epithelial cells stimulated with Aggregatibacter actinomycetemcomitans." J Periodontal Res., vol.43, 116-123, 2008.

BL. Magnanti, MT. Dorak, L. Parker, AW Craft, PW James, RJ. McNally "Sex-specific incidence and temporal trends in solid tumours in young people from Northern England, 1968-2005" BMC Cancer, in press, 2008.

S. Srinivas, J. Dai, J. Eskdale, GE. Gallagher, N. Megjugorac, G. Gallagher. "Interferon lambda-1 (IFN-l1 / IL-29) preferentially downregulates IL-13 over other Th2 cytokine responses *in vitro*." Immunology, in press, 2008

Book Chapters

G. Gallagher, J. Eskdale, R. Sabat, K. Wolk. "Interleukin-19" in: "Class-II Cytokines" A. Zdanov, editor, Transworld Research Network, p127 - 144, 2008.

G. Gallagher, MO. Moraes, J-M. Anaya. "Tumor Necrosis Factor and related genes" in: "Genetic susceptibility to infectious diseases." RA. Kaslow, JM. McNicholl & AVS. Hill, Editors, Oxford University Press, p190 - 208, 2008.

MP. Martin, MT. Dorak, M.Carrington. "Killer immunoglioulin-like receptors and erlated genes" in: "Genetic susceptibility to infectious diseases." RA. Kaslow, JM. McNicholl & AVS. Hill, Editors, Oxford University Press, p89 - 106, 2008. --

Medical Diagnostic Laboratories, L.L.C.
2439 Kuser Road
Hamilton, NJ 08690

The Laboratorian SM

Quality Assurance Q&A

Q: Why did I receive a "Verify date of collection" discrepancy report?

A: The date of specimen collection is a very important piece of information. Not only does it allow the laboratory to determine the length of specimen transport time to the testing facility, it is also used as the date of service for insurance billing purposes.

How this becomes a discrepancy:

- Conflicting Dates of Collection
- Future or past year listed
- Date of Birth listed in Date of Collection field
- Date of Collection is the same as the Date Received when the specimen was received via overnight delivery

How to prevent such discrepancies:

- Prepare the requisition form on the day the patient is seen in the office and not ahead of time
- Carefully check documents before submitting to our laboratory

If you have a question you would like addressed in future issues, please email your question(s) to QAQ&A@mdlab.com.

New Test Announcements

Now available on blood specimens:

Test 358	*Trophyrema whipelii* by Real-Time PCR
Test 359	Brucella Species *(B. suis, B. abortus, B. canis, B. ovis, B. melitensis)* by Real-Time PCR
Test 360	Francisella Species by Real-Time PCR *(F. tularensis, F. holarctica)*

Now available on *Naso*Swab™ specimens:

Test 1120	Severe Acute Respiratory Syndrome (SARS) by Real-Time PCR

Now available at Medical Diagnostic Laboratories, L.L.C.